Provider Advisory Group
Working Group for Healthcare Innovation
Tuesday September 29, 2015 - 6:30pm
Meeting Minutes

Attendees: Peter Karczmar, Al Kurose, Gary Bubly, Dieter Pohl, Steven Fera, Alan Post, Pablo Rodriguez, Sarah Fessler, Mary Dwyer, Peter Hollman, Michael Migliori, Newell Warde, Steve Detoy, Elizabeth Roberts, Lauren Lapolla, Sam Marullo

I. **Welcome – Health & Human Services Secretary Elizabeth Roberts, Chair Working Group for Healthcare Innovation**

Secretary Roberts welcomes the group, thanks folks for coming and invites the attendees to introduce themselves. Advises there was a realization there is a challenge communicating with providers. One thing to be clear is that this is a group the state wants to keep conversational, and if there are others you would like to include in this discussion please bring them to future meetings. The hope is to meet on a monthly basis, and today there will be a discussion of what we have been doing, and hear from all of you about what we should be doing.

II. **Overview of the Goals of the Working Group – Presentation by Secretary Roberts**

The PowerPoint slides discussed are available online, and upon request via email to Lauren Lapolla at lauren.lapolla@ohhs.ri.gov

Discussion during slides:

Q. Will there be policy changes that came out of this group [Reinventing Medicaid Working Group]?
Secretary Roberts: Yes, two levels, one in the spring and take the governors budget proposal of about a 9% savings and try to make it more thoughtful approach to make it more system change as opposed to just rate cuts in Medicaid. Then in July we created a report with our vision for moving forward with long-term goals in Medicaid.

Steve DeToy: The All Payer Claims Database (APCD) and the Inventory that the Department of Health (DOH) is doing are very important to the long term system changes.
Secretary Roberts: Yes, a law passed 15 months ago to do an inventory of all healthcare delivery resources in the state, and that will be going to initial report at the end of this year. About 20 different categories of provider that we are inventorying that we benchmark against other state's per capita. They have asked for many characteristics of the providers, so this document should be very useful when it comes out.

Regarding the APCD, we are the tenth or eleventh state to have an APCD which will give de-identified data on insured patients, to give detail on utilization and cost. It now has three years of data, not yet open for public consumption, but there will be a number of standard reports available, some that you would need to special request, and access for cost for certain types of utilization. There will not be any patient identifiers, not even five-digit zip code, thus no issues around personal identity determinations.

Q. A problem I have observed is an attempt to link quality to capacity, and the payers struggle with that. Trying to decide who is cost effective and where the right balance is seems to be lost. I had been chastised in the past for excessive use of stats. Just be careful to put out data with very important scrutiny; I think we could lead ourselves astray by thinking that all data will instantly solve problems.
Secretary Roberts: I agree, the APCD is a resource, for government to use and for academics to use. I agree with you that we do have to have an effective way to judge value, and the payers are stepping into that in a way that sometimes makes us happy and sometimes not. To the extent that we have resources that are publically available that is the gap this may fill. Hopefully, insofar as Health IT, hopefully this will allow you as providers to use key information to help you with your work.

III. **Provider Input & Discussion of Goals of Working Group**

The Secretary invites all to put forth questions, suggestions and comments.

Dr. Karczmar: One of the questions that I had one of the groups that is not mentioned in these discussions are those who are primarily undocumented. I haven't heard that group brought up as a topic and that is a significant issue, not only in terms of access to care, but also total cost of care.
Secretary Roberts: Interesting, as more and more we look to payment reform, we look to people who have insurance or perhaps may have access to insurance, but you're correct we don't talk about that group as often as we should. Often the hospitals absorb those costs, as do community health centers and free clinics, but Medicaid does not pay for this. Not only the undocumented immigrants, but also those who are here legally but who have not yet hit their five year stay requirement for insurance. As we put forward this work plan, we do need to call out an effective approach for improved health and protecting people from the financial burden for medical concerns.
Comment: At our health centers, the majority of our patients are undocumented and only about 11% of our patients are undocumented

and most are insured.
Sam Marullo: To level set, we are about 5% uninsured in the state right now.
Secretary Roberts: Right, but we will need to take on that issue at some point. Another issue not on this list but we should discuss is transparency, which speaks to quality. Challenging to compare costs at various locations for similar services. I consider that wrong to require people spend thousands of dollars out of pocket and not advertise ahead of time what that will cost us. An article in the NYT a few weeks ago really spoke to that issue.

Dr. Kurose: The claims data helps us a bit to understand that, but it is tricky as you have to think about appropriateness of care as well. Episode-based cost data is hard to come by. The other issue I would like to comment on, regarding transparency of pricing, if that existed those paying out of pocket could be in a position to have more procedures, but when you get into the acute care setting that may not be a part of the thought process.
Secretary Roberts: Right, and some of the biggest impact may be provider to provider.
Dr. Kurose: Between all the acute situations where price is irrelevant, and the elective situation where you cannot get the information you need, the idea that consumers with high deductibles may make more informed decisions may not play out.
Steve Detoy: We had a study group last summer on this, and the plans have an area on their website to get price data by zip code, but that didn't make a big system impact.
Secretary Roberts: That's true it may not help the system, but it does help the patient. Overall you are right, but many sides to this.

Unidentified Commenter: Regarding prescription drugs, we are all learning codes to input drug information into systems, but unclear why the costs and the dosage cannot be there to give physicians an awareness. We should have access to the costs within our IT systems, particularly with prescriptions and labs to an extent.
Unidentified Commenter: BCBSRI has that project, embedding pharmacists in Primary Care practices to do just that.
Secretary Roberts: Some pharmacists may know that cost, but not all. The other challenge is what are you paying vs. what does it cost. Often people do not think about the cost rather just what it costs to them.

Dr. Pohl: Big educational component. In my office I have a big list of what I am using and what I am doing. Many studies and many projects out there providing information on where you want and can save on materials, but every surgeon may have preferences for tools or medications, and there may be data out there to suggest a cost change.

But need more education on that.

Dr. Kurose: In a related vein, other doctors do not look at the pricing and the reason may be that they do not have incentives to do so. So when thinking about what the state can do, while we get bogged down in tools, but until we have significant penetration with modernized business models, there may not be more that we can do. Think about how the state can help with higher penetration for quality cost of care business models. If the cost performance of all those surgeons wen to their bottom line, that might affect their decisions.
Secretary Roberts: Who has the leverage to redefine that?
Dr. Kurose: There is a big cultural barrier, as many physicians are pressed for time as it is, and the status quo is economically attractive enough and the alternative seems risky enough they don't get off the starting line.

Dr. Migliori: You see that happen in private practice, educating on cost, but in hospital facilities you do have access to that information quickly (on cost). There may not be appreciation of spending a million dollars a year on one drug in an eye clinic than another drug which may cost less and need to be administered less.
Dr. Karczmar: Veterans' Affairs is very effective at doing this.

Sam Marullo: From the state's perspective, how can we help?
Dr. Migliori: There needs to be a culture in the institutional administrations to look at that, and I am not confident this is the highest priority. You need champions within the physicians and nurses to push this idea, build on one success to expand within institutions. I don't think the waste is intentional, but rather stemming from a lack of information.

Dr. Kurose: Yet this is basic operations 101 type work, and all over healthcare I feel there is a disconnect between clinicians and those with operational business expertise where that connection could be made.
Secretary Roberts: The lever we have is where, and how, we pay. The question is how do you use payment to drive efficiency in a way that is positive, rather than efficiency that is limiting access or cutting costs. We are struggling that we may not be
Dr. Pohl: I have read about those who have done this on the institutional side. The physician who took on that role is key – though getting a champion to take that on is tricky. Physician-driven would be critical. The state can help by creating a study and subsidize physician champions for year one and two, and then build on the momentum to keep a different quality incentive.

Dr. Karczmar: I think you need to have some incentive, and frankly there is nothing better than financial incentive. I do not think you can impact cost of care on a larger scale without financial incentive.

Dr. Kurose: One of our doctors said to me last week, 'this is all good and I am glad our quality has improved, but there better be a reward at the end of this.' That is a reality, and important thing to think about. Getting people off the dime and changing the business model is not something we have discussed much.

Unidentified Commenter: One of the things we have become used to is paying for checking boxes, and process metrics. For years I see boxes checked, claiming it as quality, but there is no connection between those incentives and actual outcomes. Greasing utilization that will not produce outcomes for many years, so there is a possibility that by pushing people to be more quality oriented for the long term, you end up spending more in the short term.
Dr. Kurose: I think the office of the actuary in federal government did a study on that.
Unidentified Commenter: the language we need to figure out is that if we work on quality measures you save less money.

Unidentified Commenter: Quality improvement and cost, i.e. less likely to get cancer than you were in the first place. Lots of basic idea, pay for performance, price transformation, but some things you need to build. When people want to go out to buy better performing Primary Care services, it wasn't available, so we had to build it up through the Primary Care Medical Home (PCMH) structures. The idea that it may happen through a free market, everyone do a good job wasn't working. Thus [Dr. Kurose's] point about having an alternative is important, but I do not know what those rules are. For a lot of folks looking at alternative payment mechanisms, the rules are not clear for hospital systems for example, whole host of things like the PCMH is to look at how to change it though regulation, through payment reform, through public pressure. A key thing is create enough rules for the road to make a decision. I brought up in the past the idea that the health plans will say they are going to pay for performance, but they do not say what that will mean, when it will happen, and how that is defined. The feds at least are clear in their outline of plans. When someone said you will get X % for meaningful use, the provider can do the math. We do not have a lot of ideas for the way things are going in terms of reasonable planning.

Secretary Roberts: And everything that you just described as public, is a federal program. And we struggle with that to, as well, to look at system wide say with an all payer approach, how we make it all meld. It is not required that they make it publically available and thus it is proprietary. Most medical provider info is not publically available, except in the aggregate HEDIS measures.
Dr. Hollman: It turns out if you see a gynecologist you have almost a 100% chance of getting pap smears, within guidelines, even if they are

not required. Often we see the same thing on a lot of measures. That is why you need groups to see the measures that way, find out where the differences are there.

Dr. Post: We know how in the marketing agency new and improved is always better, but often new and improved is not necessarily better. Many of the common problems people go see their doctors for, sometimes the lower tech, lower cost, higher safety providers are really a means to save the system mountains of money. As a chiropractic physician I am a portal of entry provider, I evaluate a patient who comes in say with neck pain, determine an initial diagnosis, and then either refer or treat. My malpractice insurance for $2million, $6million, I pay less than $1000 a year. If my care can be that safe, just imagine the cumulative effects of the other types of problems that drive the cost of the system. It is skin in the game, but incorporating lower tech, lower cost, proven high safety providers as a means of savings. Interesting that in chiropractic, we are in Medicare in a limited way, but cannot opt out. If they were allowed to opt out, and many would, the numbers would sky rocket. The vast majority of things people go to a doctor for can be dealt with in a lower cost setting. Consider ways to include alternative settings into the system as a means of saving costs.

Secretary Roberts: I am interested as the ACOs develop, how much what is under paid for in the fee for service (FFS) environment is changed and paid for as it may help bring down system costs?
Dr. Kurose: We have been talking about it, and a back pain program may be one we may be considering as our other population health management programs continue.
Secretary Roberts: Interesting to think about as we change paying for things, how much undervalued parts of our system become more valued.
Unidentified Comment: Alternative methods of alleviating physical pain, physical therapy can be very helpful, but as it is often not covered, the patient will follow up with more expensive yet covered care.

Dr. Post: In the Connecticut systems they started a pilot, and quickly ended it and became a part of the system as it was so effective, to include more chiropractic work in the system. In 2010 the RI legislature commissioned a study to include studies on that
Unidentified Comment: I lived in that environment, and the flaw in the study, the criteria for admitting people to that program were already hooked on painkillers and with certain Emergency Room visits. Those people are hard to move, and I think the opportunity is with those before they hit that group. I hope for a wider look so that we can see those positive numbers of reduction of pain through alternative measures. Key when studying these things, look at what you are doing, and make sure it is valid and that there aren't things that we left out. Big picture, we will

make mistakes as a state, but how successful we can be as a state is to see those mistakes, make corrections and move forward, without taking down already effective programs.

Q. Is there a way to dis-incentivize providers from prescribing auto refills at pharmacies? If there is a way to incentivize per discontinuation that may be helpful. The doctor may tell a patient halfway through a course that they are all set, but the prescription keeps going.
Secretary Roberts: Very interesting – lets think about having a full topic on pharmacy.

Dr. Karczmar: Running low on time, so in general terms you have outlined what you would like this group to bring to you at these meetings, but can you be more specific on what to take back?

Secretary Roberts: today we came with a "here is what is going on." And next time we will not have to do that, so next time present the major issues we are thinking about a head of time and ask you to come prepared to speak to those. If we could have a time every month to get together with say 3-5 hot issues (and you may recommend issues you would like on the table), that would be how I would like to proceed with this very useful group. One of my biggest struggles is how to engage effectively with those providing care as our work days overlap. I have had success with morning meetings, and evening meetings with physicians.

Dr. Kurose: If there is a way to message the work on the larger working group to this group that would be very helpful.

Secretary Roberts: Absolutely.

IV. Public Comment – No additional comment put forward by the public at this time.

V. Adjourn

Oct 27/28 tentative next date.